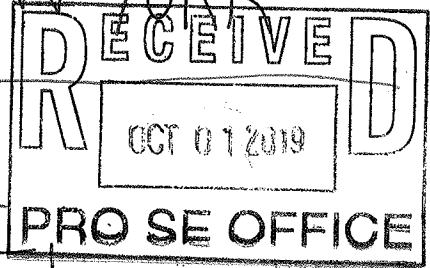


Case 1:19-cv-01447-LJV Document 12 Filed 09/30/19 Page 1 of 1

UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF NEW YORK

CIVIL COVER SHEET



1. (a) Plaintiff(s): Robert W. Johnson

(b) Bronx County

19 CV 9127

(c) 3345 Fish Ave. : APT. 1 : Bronx, NY 10469

Defendants: Spadafora & Verrastro LLP;
Verrastro James P., James P. Verrastro,
Joseph C. Todoro, Joseph Anthony Todoro,
God Apartments Belmont Management,
Belmont Management Company Inc.,
God City Housing, Belmont Development,
Belmont Construction, Ryan Hudspeth
& Social Security Administration.

2. Basis of Jurisdiction: 28 U.S.C
§ 1331: Federal Question.

A. Basis For Federal Jurisdiction:

Ineffective Counsel, Breach of Contracts, Discrimination, Due Process Violations, Civil Rights Violations, Abuse of Authority, Denial of Plaintiff's Civil Rights & Disabilities & U.S. Constitutional Violations.

3. Statement of Claim:

Spadafora & Verrastro LLP: Verrastro James P. failed to represent Plaintiff in 01/06/14 God City Housing bicycle accident due to Belmont Housing Development failure to keep facility protected from civilians being injured due to bad weather conditions. God City Housing failed to accept responsibility for Plaintiff's injuries that have worsened since 01/06/14. Social Security Administration failed to grant Plaintiff benefits due to SSA assumptions

Case 1:19-cv-01447-LJV Document 2 Filed 09/30/19 Page 3 of 7
Related Cases: Second Circuit Courts
Docket "18-2399".

Origin: Original Proceeding.

Jury Demand: Yes.

Basis of Jurisdiction For Jury Demand is
28 U.S.C § 1331: Federal Question.

Nature of Suit: Civil Rights 440: Other
Civil Rights.

Relief Sought: \$550 Trillion For Punitive
Damages & \$400 Billion For Future Punitive
Damages; Judicial Sanctions; All Other
Actions Deemed Just & Proper; 100%
Ownership of Defendants Corporations.

September 20, 2019

Robert W. Johnson
Robert W. Johnson
3345 Fish Ave. - APT. 1
Bronx, NY 10469

~~EXHIBIT~~ NO. B22F

PAGE: 2 OF 4

EMERGENCY SERVICE FACESHEET (Page 2 of 2)

EXHIBIT NO. B22F

PAGE 3 OF 4

NAME JOHNSON, ROBERT		REGISTRATION NUMBER V00003287800		MEDICAL RECORD NUMBER M000810239	
SOCIAL SECURITY NO. 078-78-3909		ARRIVAL TIME 01/08/14 0957		TRIAGE BY CHARRING	
PRIMARY CARE PROVIDER		BIRTHDATE 02/26/1984		AGE 29	
INS. PLAN HAHWC		SEX M		ACUITY 3	
TELEPHONE		ROOM WR -		REFERRAL TIME	

CHIEF COMPLAINT Neck Pain	ALLERGIES No Known Allerg
-------------------------------------	-------------------------------------

LAST ER VISIT: 12/25/12	ARRIVAL MODE: Self	EMS AGENCY/UNIT:	TRAVEL LAST 2 WK: N	WHERE TO:
LAST ADMIT DATE:	LAST DISCHARGE DATE:	ADMIT PHYSICIAN:	ADMIT SERVICE:	
HIV CONSENT: TRIAGED	V00003287800			
DNR ORDER: N	FORM WITH PATIENT: N	BILL OF RIGHTS GIVEN TO PATIENT/FAMILY:	TRANSFER IN: N	TRANSFER FROM:
LIMITATION OF TREATMENT: N	RECEIVED HIPAA NOTICE OF PRIVACY PRACTICES: Y	HEALTH CARE PROXY: N	HEALTH CARE PROXY AGENT:	HOSPICE: N

PROCEDURE NOTES	Reasons:	TIME	RE-EVALUATION	CRITICAL CARE
<input type="checkbox"/> Conscious sedation	<input type="checkbox"/> RSI Intubation			30-74 mins 75-104 mins 105-134 mins 135-164 mins 165-194 mins
<input type="checkbox"/> personally supervised the procedures as noted above.				

ATTENDING NOTE
<i>do not band LBP 3/4 full no ch back no HA no more ch & curbing</i>

CONST	<input type="checkbox"/> Rev	Mean of at least 3 vs signs:	GU	<input type="checkbox"/> NL	Ex. genit/vag	SOC. HX	MAR ST	M S D	H O
	<input type="checkbox"/> NL	Gen appearance of patient		<input type="checkbox"/> NL	Urethra				
EYES	<input checked="" type="checkbox"/> NL	Insp conj/ids		<input type="checkbox"/> NL	Bladder				
	<input type="checkbox"/> NL	Exam pupils/lenses		<input type="checkbox"/> NL	Cervix				
	<input type="checkbox"/> NL	Ophthalmoscope exam		<input type="checkbox"/> NL	Uterus				
ENT	<input type="checkbox"/> NL	Ext insp ears/nose	Lymph	<input type="checkbox"/> NL	Adnexa/parametria				
	<input type="checkbox"/> NL	Otoscope exam		<input type="checkbox"/> NL	Palp of nodes in 2+ areas:				
	<input type="checkbox"/> NL	Assess hearing		<input type="checkbox"/> NL	Neck				
	<input type="checkbox"/> NL	Nasal mucosa/septum/turb		<input type="checkbox"/> NL	Axillae				
	<input type="checkbox"/> NL	Lips/teeth/gums		<input type="checkbox"/> NL	Groin				
	<input type="checkbox"/> NL	Exam oropharynx		<input type="checkbox"/> NL	Other				
Neck	<input type="checkbox"/> NL	Exam neck	Muscl	<input checked="" type="checkbox"/> NL	Exam gait/station				
	<input type="checkbox"/> NL	Exam thyroid	skel	<input type="checkbox"/> NL	Exam joints/bones/muscles:				
Resp	<input checked="" type="checkbox"/> NL	Resp effort		<input type="checkbox"/> NL	Insp and/or palp				
	<input type="checkbox"/> NL	Parcus chest		<input type="checkbox"/> NL	Range of motion				
	<input type="checkbox"/> NL	Palp chest		<input type="checkbox"/> NL	Stability				
	<input checked="" type="checkbox"/> NL	Aus lungs		<input type="checkbox"/> NL	Muscle strength				
CV	<input type="checkbox"/> NL	Palp heart	Skin	<input type="checkbox"/> NL	Back				
	<input type="checkbox"/> NL	Aus heart		<input type="checkbox"/> NL	Palp				
		Exam of:	Neuro	<input checked="" type="checkbox"/> NL	Insp skin/subQ tissue				
	<input type="checkbox"/> NL	carotid art		<input type="checkbox"/> NL	Palp skin/subQ tissue				
	<input type="checkbox"/> NL	abd aorta		<input type="checkbox"/> NL	Test CN nerves				
	<input type="checkbox"/> NL	feml art		<input checked="" type="checkbox"/> NL	OTR's				
	<input type="checkbox"/> NL	pedal pulses		<input type="checkbox"/> NL	Sensation				
	<input type="checkbox"/> NL	extrem - edema/varicosities	Psych	<input type="checkbox"/> NL	Desc judgment/insight				
Chest	<input type="checkbox"/> NL	Insp breasts		<input type="checkbox"/> NL	Brief assess MS:				
(Brsts)	<input type="checkbox"/> NL	Palp breasts/axillae		<input checked="" type="checkbox"/> NL	Orient to time/place/person				
GI	<input type="checkbox"/> NL	Abd-massae/tender		<input checked="" type="checkbox"/> NL	Recent/remote memory				
(Abd)	<input type="checkbox"/> NL	Liver/spleen		<input type="checkbox"/> NL	Mood/affect				
	<input type="checkbox"/> NL	Hernia							
	<input type="checkbox"/> NL	Rectum							
	<input type="checkbox"/> NL	Stool occult blood							
GU	<input type="checkbox"/> NL	Scrotal contents							
	<input type="checkbox"/> NL	Penis							
	<input type="checkbox"/> NL	Prostate							

Rev. 10/13	ED 002	SIGNATURE R. Kreise MD	DATE / TIME 1/6/14	PT SEEN & DISCUSSED WITH RESIDENT / EXT-HPI AN ROS / PFSH / DX / RX REVIEWED / AGREE
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M000810239



V00003287800



Name: **JOHNSON, ROBERT**
Med. Rec. #: **M000910238** Date of Birth: **02/26/1984** Age: **29**
Vish #: **Y00003887890** Insurance: **HARTFORD-COMPENSATION**
Service Date: **01/06/14** Service Time: **0957** Room:

Check with your primary provider or prescribing specialist for regular medication dosages and continued appropriateness of medications.
☐ Please give a copy of this information to your primary care provider

Take medications only as prescribed:		<input type="checkbox"/> Take following medicine(s) in addition to your regular medicine(s).
		<input type="checkbox"/> Take following medicine(s) and make changes to your present medicine(s) as noted below.
Prescription Monitoring Program reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No (Exempt: Emergency Department; quantity does not exceed 5 day supply)		
NO.	MEDICINE	INSTRUCTIONS
MED. #1	<i>None</i>	
MED. #2		
MED. #3		

Restrictions:

☒ None Return Date / / No job modification necessary
☐ Modified Activity Start Date / / End Date / / Modified duty described below:
☐ Off Work/School Start Date / / End Date / /

Modify Activity As Follows

☐ **Do Not** operate moving machinery/motor vehicles/bicycles ☐ **Do Not** work above ground level (climbing ladders, elevated platforms, catwalks, etc.)
☐ No Pushing/Pulling/Lifting with arm/shoulder ☐ Right ☐ Left ☐ No Flexion/Extension of elbow ☐ Right ☐ Left
☐ Limited Lifting/Carrying, not to exceed ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs ☐ No Bending/Twisting at ☐ Waist ☐ Neck
☐ Must have a sit down job ☐ No Squatting/Kneeling

Additional Instructions:

None

Follow up Physician:

Phone Number:

☐ Follow up only if not feeling better in days

☐ Must follow up within days

Return to ER if you have the following symptoms:

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CULTURE RESULTS CALL 716-961-7723 AFTER 48 HOURS

None

Physician/Nursing Personnel Signature

I understand treatment and instructions given to me.

Patient Signature

Date

Time

☐ **TRANSPORTATION APPROPRIATE FOR CONDITION**

- You have received emergency treatment at E.C.M.C. Follow the instructions carefully. If your condition continues to deteriorate, or unexpected symptoms develop, call the follow-up physician for advice or return to the Emergency Department for re-evaluation. Otherwise follow up as instructed. Call the doctor's office the next day for an appointment.
- If X-rays were taken, they were interpreted by an Emergency Physician while you were being treated in the E.D. These tests will be reviewed again by appropriate specialists the next day. You will be notified immediately in case of additional findings.

0522636

Rev. 10/13

HUPJNS.002

M000910238

Y00003887890

ROBERT W. JOHNSON
334S FISH AVE.
APT. 1
BRONX, NY 10007

USMC
STNY 7

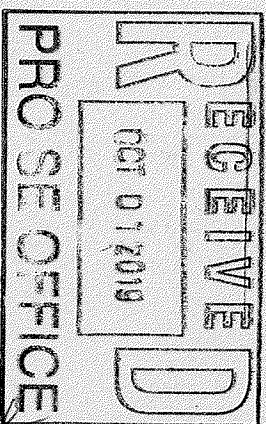
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